TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Sentry Casualty Co

MFDR Tracking Number
M4-16-0955-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills have been denied by the carrier stating preauthorization was not obtained. Memorial Compounding Pharmacy rebuttal stated this medication does not warrant preauthorization. Reconsideration has been denied."

Amount in Dispute: $489.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: 28 Texas Administrative Code 133.307(d)91)states in pertinent part, "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The Division received an acknowledgment of the medical fee dispute on December 17, 2015. No response was received. Therefore, this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2015	Pharmacy Services	$489.96	$489.96

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.540 sets out the preauthorization requirements for pharmaceuticals subject to the closed formulary and certified networks.

3. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmaceutical services.
4. The services in dispute were denied with the following rejection/denial codes.
   - 197 – Precertification/authorization/notification absent
   - W3 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the carrier's denial of the services in disputer supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the request due additional payment?

Findings

1. 28 Texas Administrative Code §134.540(b) states,

   Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for:

   (1) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

   (2) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and

   (3) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

Review of the submitted DWC066 finds the following medications; Meloxicam, Flurbiprofen, Tramadol HCL, Cyclobenzaprine HCL, Bupivicaine HCL. While Appendix A of the ODG Workers' Compensation Drug Formulary lists, Tramadol ER as an "N" classified medication, insufficient evidence was found to support this was the medication provided to the claimant. The remaining medications were not found to be "N" drugs. Therefore, the carriers' denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. The dates of service are for pharmaceutical services. 28 Texas Administrative Code §134.503(c) states,

   The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

   (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

The maximum allowable reimbursement will be calculated as follows:

Date of service	Name of Medication	Reported units	Amount billed	MAR (AWP per unit) x (number of units) x 1.25 +$4.00
July 14, 2015	Meloxican	1	$35.04	$194.67 x 1 x 1.25 + $4.00 = $247.34
July 14, 2015	Flurbiprofen	5	$168.72	$36.58000 x 5 x 1.25 + 4= $232.63

July 14, 2015	Tramadol HCL	6	$168.00	$36.30000 x 6 x 1.25 + 4 = $276.25
July 14, 2015	Cyclobenzaprine HCL	2	$80.37	$46.33200 x 2 x 1.25 + 4 = $119.83
July 14, 2015	Bupivacaine	1	$46.02	$45.60000 x 1 x 1.25 + 4 = $61.00

Based on the submitted DWC066, Box 21, the Generic NDC is for **bulk powder**. The total allowed amount is $937.05. The requestor is seeking $489.96, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $489.96.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $489.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February , 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.